Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004773	A. BUILDING _____ B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON COUNTY HOSPITAL	1141 HOSPITAL DR NW CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Complaint number: IN00109165 Unsubstantiated: lack of sufficient evidence Date of survey: 08-23-12 Facility number: 004773 Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Harrison County Hospital is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules. QA: claughlin 08/28/12	S 000		